TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14431 — 14437

1. PLACE OF DEATH
a. COUNTY: ST. MARY,S — MARYLAND — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): LEONARDTOWN
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): ST. MARY,S HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: ST. MARY,S
c. CITY OR TOWN (If outside corporate limits, write RURAL and give neorest town): LEXINGTON PARK
d. STREET ADDRESS: BOX 3130 LEXINGTON PARK Md.
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First JOSEPH — Middle SHAPALEY — Last BARNES
4. DATE OF DEATH: Month OCTOBER — Day 28 — Year 1967
5. SEX: MALE
6. COLOR OR RACE: NEGRO
7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH: SEPT. 25 1887
9. AGE (In years last birthday): 80 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): FARMER
10b. KIND OF BUSINESS OR INDUSTRY: FARMING
11. BIRTHPLACE (County & State, or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: HENRY BARNES
14. MOTHER'S MAIDEN NAME: DELIAH BARNES

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: 218-38-8600
17. INFORMANT: Address: MRS. RUTH PORTEE LEXINGTON PARK Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 6 Hours
331X
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Hypertensive Vascular Disease
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work [ ] Not While at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I **certify** that (I) (~~this hospital~~) attended the deceased from Oct 28, 1967 to Oct 28, 1967 that (I) (~~we~~) last saw the deceased alive an Oct 28 1967, and that death occurred at 2:45 M, from causes and on the date stated above.

22a. SIGNATURE: W. H. Patrick M.D. — ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ] — 22b. DATE SIGNED: 10-29-67
22c. PHYSICIAN'S NAME (Type): W. H. PATRICK M.D.
22d. ADDRESS: LEXINGTON PARK MARYLAND

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 10/31/1967
23c. NAME OF CEMETERY OR CREMATORY: HOLY FACE CEM.
23d. LOCATION (City or Town) (County) (State): GREAT MILLS ST. MARY,S Md.

24. FUNERAL DIRECTOR: JOHN M. WELCH — ADDRESS: LEONARDTOWN MARYLAND
25a. REC'D BY REGISTRAR DATE NOV 2 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14432 15952

CERTIFICATE OF DEATH

1. PLACE OF DEATH
a. COUNTY: St. Mary's — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): LEONARDTOWN
c. LENGTH OF STAY IN 1b: 19 DAYS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): St. Mary's Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAND b. COUNTY: St. Mary's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CHAPTICO
d. STREET ADDRESS: RURAL
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First MARY Middle PEARL Last BOYD
4. DATE OF DEATH: Month OCTOBER Day 29, Year 19 67

5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]
8. DATE OF BIRTH: Aug. 5, 1892
9. AGE (In years last birthday): 75 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (County & State, or foreign country): CHAPTICO, MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: FREDERICK CARROLL [illegible] DAVIS
14. MOTHER'S MAIDEN NAME: MARY EVELYN LOVE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: 579-28-6376
17. INFORMANT Address: GEORGE F. BOYD CHAPTICO, MARYLAND

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Circulatory Collapse — INTERVAL BETWEEN ONSET AND DEATH: Hrs.
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Arteriosclerotic Insufficiency — Days
DUE TO
(c): Pyelonephritis & Septicemia — Wks.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Coronary Artery Disease
19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury ~~in Part I or Part II~~ of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work [ ] Not While at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from _____, 19 67 to 10/29, 19 67, that (I) (~~saw~~) last saw the deceased alive on 10/29, 19 67, and that death occurred at _____ M, from causes and on the date stated above.

22a. SIGNATURE: [signature] M.D. ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]
22b. DATE SIGNED: 10/31/67
22c. PHYSICIAN'S NAME (Type): JAMES P. JARBOE M. D.
22d. ADDRESS: GREAT MILLS, MARYLAND

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: ~~EX.~~ 11-2-67
23c. NAME OF CEMETERY OR CREMATORY: ST. JOSEPHS CHURCH CEMETERY
23d. LOCATION (City or Town) (County) (State): MORGANZA, ST. MARY'S, MD.

24. FUNERAL DIRECTOR ADDRESS: W. CLARKE MATTINGLEY LEONARDTOWN, MARYLAND
25a. REC'D BY REGISTRAR DATE: NOV 8 1967
25b. REGISTRAR'S SIGNATURE: [signature] Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14433

CERTIFICATE OF DEATH

14433

1. PLACE OF DEATH
a. COUNTY: ST. MARY,S
MARYLAND MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): LEONARDTOWN
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): ST. MARY,S HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ST. MARY,S
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): LEXINGTON PARK Md.
d. STREET ADDRESS: LEXINGTON PARK
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
MARY	ETHEL	BRISCOE	OCTOBER	27	1967

5. SEX	6. COLOR OR RACE	7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
FEMALE	NEGRO		1/14/1917	50 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country)	12. CITIZEN OF WHAT COUNTRY?
HOUSEKEEPER	DOMESTIC	ST. MARY,S MARYLAND	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
RANDOLPH BRISCOE	DORA REED

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address	
NO	343-20-6523	BARBARA E. BANKINS	RT.2, BOX 384 HOLLYWOOD Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinoma of pancreas with metastasis
DUE TO (b):
DUE TO (c):
157 X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work ☐ Not While at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
			Oct 27 67	Oct 27 67	

21. **I certify** that (I) (this hospital) attended the deceased from Oct 24 67 to ___ pm ___, 19__, that (I) (we) last saw the deceased alive on Oct 27 1967, and that death occurred at 2:55 PM, from causes and on the date stated above.

22a. SIGNATURE	M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐	22b. DATE SIGNED
J C Roa MD		10 - 30 - 67

22c. PHYSICIAN'S NAME (Type)	22d. ADDRESS
J. C. ROA, M. D.	LEXINGTON PARK, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town)	(County)	(State)
BURIAL	10/30/1967	ST. PETERS CLAVERS	RIDGE	ST. MARY,S	Md.

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
JOHN M. WELCH	LEONARDTOWN MARYLAND	NOV 2 1967	Blanche Judge

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14434

CERTIFICATE OF DEATH

14439

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 M1
20 M 1766

1. PLACE OF DEATH a. COUNTY: ST. MARY'S — MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CHARLOTTE HALL c. LENGTH OF STAY IN 1b: d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):	2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE: MARYLAND b. COUNTY: ST. MARY'S c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CHARLOTTE HALL d. STREET ADDRESS: e. IS RESIDENCE ON A FARM? YES ☐ NO ☒
3. NAME OF DECEASED (Type or print): First OLGA; Middle BEDELL; Last BURGEE	4. DATE OF DEATH: Month OCTOBER; Day 31; Year 19 67
5. SEX: FEMALE	6. COLOR OR RACE: WHITE
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH: SEPT. 14, 1914
9. AGE (In years last birthday): 53 yrs.	IF UNDER 1 YEAR: Months; Days. IF UNDER 24 HRS.: Hours; Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE	10b. KIND OF BUSINESS OR INDUSTRY: DOMESTIC
11. BIRTHPLACE (County & State, or foreign country): WASHINGTON, D.C.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: CHARLES J. BEDELL	14. MOTHER'S MAIDEN NAME: GRACE MILLER
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes give war or dates of service)	16. SOCIAL SECURITY NO.: 577-03-2706
17. INFORMANT: MAJ. MIEL D. BURGEE	Address: CHARLOTTE HALL, MD.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinoma - lung - rt. — INTERVAL BETWEEN ONSET AND DEATH: 1 yr.
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 163 X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Jan ____, 1948 to Oct 31, 1967, that (I) (we) last saw the deceased alive on Oct 31 1967, and that death occurred at 3 P M, from causes and on the date stated above.

22a. SIGNATURE: Roy Guyther — M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: NOV. 2, 1967

22c. PHYSICIAN'S NAME (Type): J. ROY GUYTHER, M.D.

22d. ADDRESS: MECHANICSVILLE, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
BURIAL	NOV. 3, 1967	MT. OLIVET CEMETERY	FREDERICK, MD.

24a. FUNERAL DIRECTOR: JOHN M. WELCH — ADDRESS: LEONARDTOWN, MD.

25a. REC'D BY REGISTRAR DATE NOV 7 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14435

CERTIFICATE OF DEATH

14440

1. PLACE OF DEATH
a. COUNTY: St. Mary's — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): LEONARDTOWN
c. LENGTH OF STAY IN 1b: DOA
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street oddress): St. Mary's Hospital

2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: St. Mary's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give neorest town): Rural Avenue
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First: Mary — Middle: Maude — Last: Cheseldine
4. DATE OF DEATH: Month: October — Day: 17, — Year: 19 67
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: March 13, 1891
9. AGE (In years last birthday): 76 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Francis Owens
14. MOTHER'S MAIDEN NAME: Genevieve Cooke

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Carl C. Cheseldine — Address: Avenue, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiac arrhythmia — INTERVAL BETWEEN ONSET AND DEATH: minutes
DUE TO (b): Arteriosclerotic Heart Disease — 10 years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c): Diabetes mellitus — 10 years.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)
20c. TIME OF INJURY Month, Doy, Yeor Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____ 19____, and that death occurred at _____M, from causes and on the date stated above.

22a. SIGNATURE: John F. Fenwick — M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 10.18.67
22c. PHYSICIAN'S NAME (Type): John F. Fenwick M.D.
22d. ADDRESS: Leonardtown, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Oct. 20, 1967
23c. NAME OF CEMETERY OR CREMATORY: All Saints Cemetery
23d. LOCATION (City or Town) (County) (State): Oakley, St. Mary's, Maryland

24. FUNERAL DIRECTOR: W. Clarke Mattingley — ADDRESS: Leonardtown, Maryland
25a. REC'D BY REGISTRAR: DATE: OCT 20 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

2430 Item #9 Film #0393 10/9/67 ph 14341

1. PLACE OF DEATH
a. COUNTY: St. Mary's — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Leonardtown
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): St. Mary's Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Charles
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Aquasco
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Frederick — Middle: Skinner — Last: Chichester SR
4. DATE OF DEATH: Month: October — Day: 1 — Year: 1967
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 11-25-1894
9. AGE (In years last birthday): 72 73 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): FARMER
10b. KIND OF BUSINESS OR INDUSTRY: TOBACCO
11. BIRTHPLACE (County & State, or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U. S.
13. FATHER'S NAME: William S. Chichester
14. MOTHER'S MAIDEN NAME: Priscilla Wood
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): YES (If yes give war or dates of service): WWI
16. SOCIAL SECURITY NO.: 217-36-7848
17. INFORMANT: Address: PRISCILLA DYSON, AQUASCO, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: 1 wk
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Bronchitis - emphysema
DUE TO (c):
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): arteriosclerotic cardiovascular
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Mar, 19 [illegible], to Oct, 19 67, that (I) (we) last saw the deceased alive on Sept 30 1967, and that death occurred at M, from the causes and on the date stated above.

22a. SIGNATURE: J. Roy Guyther — M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 10-2-67
22c. PHYSICIAN'S NAME (Type): J. ROY GUYTHER
22d. ADDRESS: MECHANICSVILLE, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 10-4-67
23c. NAME OF CEMETERY OR CREMATORY: ST MARYS CEM.
23d. LOCATION (City, town or county) (State): AQUASCO MD.
24. FUNERAL DIRECTOR: ADDRESS: THE HUNTT FUNERAL HOME, WALDORF, MD
25a. REC'D BY REGISTRAR — DATE: OCT 5 1967
25b. REGISTRAR'S SIGNATURE: [signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 3 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 20M 1/65

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14437

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14442

1 PLACE OF DEATH
a COUNTY: St. Mary's — MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): St. Mary's Hospital
c. LENGTH OF STAY IN 1b: ½ HOUR
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Leonardtown, Maryland

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a STATE: Maryland
b COUNTY: St. Mary's
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): St. Inigoes
d STREET ADDRESS:
e IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: ISAAC XXXXX Middle: A Last: CHISLEY

4 DATE OF DEATH: Month: 10 Day: 16 Year: 19 67

5. SEX: Male

6. COLOR OR RACE: Colored

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8 DATE OF BIRTH: JUNE 1, 1922

9. AGE (In years last birthday): 45XXX yrs

IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): LABORED

10b KIND OF BUSINESS OR INDUSTRY:

11 BIRTHPLACE (State or foreign country): ST. INIGOES, MARYLAND

12 CITIZEN OF WHAT COUNTRY? U.S.A.

13 FATHER'S NAME: HARRY CHISLEY

14 MOTHER'S MAIDEN NAME: ALICE CARTER

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service):

16. SOCIAL SECURITY NO: 220-16-5054

17 INFORMANT: Address: ESTELLE G. CHISLEY ST. INIGOES, MARYLAND

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a) (b), and (c))
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Arteriosclerotic cardiovascular disease — INTERVAL BETWEEN ONSET AND DEATH
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 42m, 002.1
DUE TO (c):

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Pulmonary tuberculosis

19 WAS AUTOPSY PERFORMED? YES ☒ NO XX

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH

20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d INJURY OCCURRED While at work ☐ Not While at work ☐

20e PLACE OF INJURY (Home farm factory, street office bldg., etc.)

20f (City or town) (County) (State)

21 I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection XX, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Werner U. Spitz M.D.

EXAMINER'S NAME (Type): WERNER U. SPITZ, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
DEPUTY MEDICAL EXAMINER ☐

Address (Street, city, town, or county):

22. DATE SIGNED: 10-16-67

23a BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b DATE THEREOF: Oct. 19, 1967

23c NAME OF CEMETERY OR CREMATORY: ST. PETER CLAVERS CEMETERY

23d LOCATION (City or Town) (County) (State): RIDGE, ST. MARY'S, MARYLAND

24 FUNERAL DIRECTOR ADDRESS: W. CLARKE MATTINGLEY LEONARDTOWN, MARYLAND

25a RECD BY REGISTRAR DATE: OCT 18 1967

25b REGISTRAR'S SIGNATURE: [illegible] Judge

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18 Give Pages 1, 2, and 3 to the funeral director Page 4 should be forwarded to the Chief Medical Examiner's Office along with form HM3 Pages 1, 2, and 3 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

14638 — 1-1444

1. PLACE OF DEATH
a. COUNTY: St. Mary's — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Leonardtown
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): St. Mary's Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: St. Mary's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Lexington Park
d. STREET ADDRESS: Route 1 Box 104
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Elizabeth — Middle: (None) — Last: Demko

4. DATE OF DEATH: Month: October — Day: 30 — Year: 19 67

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Nov 19 1887.

9. AGE (In years last birthday): 79 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE

10b. KIND OF BUSINESS OR INDUSTRY: DOMESTIC

11. BIRTHPLACE (County & State, or foreign country): CZECKOSOLVAKIA

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John Koval

14. MOTHER'S MAIDEN NAME: UNKNOWN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes give war or dates of service)

16. SOCIAL SECURITY NO.: N/A

17. INFORMANT: MRS. GRACE NORWOOD — Address: 4005 Pinewood Ave. BALTIMORE, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Auricular fibrillation with

Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last.
DUE TO (b): embolism. Hypertensive arteriosclerotic
DUE TO (c): cardiovasular disease. Congestive heart failure

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from June, 1965 to Oct 30, 1967, that (I) (we) last saw the deceased alive on Oct 30 19 67, and that death occurred at 7:20 P.M., from the causes and on the date stated above.

22a. SIGNATURE: J. C. Roa M.D. — M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 10 - 30 - 67

22c. PHYSICIAN'S NAME (Type): J. C. ROA, M. D.

22d. ADDRESS: LEXINGTON PARK, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 11 - 2 - 67

23c. NAME OF CEMETERY OR CREMATORY: ST. JAMES CEMETERY

23d. LOCATION (City, town or county) (State): LEXINGTON PARK, MD.

24. FUNERAL DIRECTOR: JOHN M. WELCH — ADDRESS: LEONARDTOWN, MD.

25a. REC'D BY REGISTRAR DATE: NOV 2 1967 — 25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15 (1) 20M 1/64

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

4439

CERTIFICATE OF DEATH

14445

1. PLACE OF DEATH
a. COUNTY: St. Mary's — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): LEONARDTOWN
c. LENGTH OF STAY IN 1b: 11 DAYS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): St. Mary's Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: CHARLES
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL PORT TOBACCO
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First MARY — Middle Lucille ~~Luckie~~ — Last DePew

4. DATE OF DEATH: Month OCTOBER — Day 5, — Year 19 67

5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: MAY 5, 1914
9. AGE (In years last birthday): 53 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework
10b. KIND OF BUSINESS OR INDUSTRY: Domestic
11. BIRTHPLACE (County & State, or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Daniel Rice
14. MOTHER'S MAIDEN NAME: Maude Wenk

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service): No
16. SOCIAL SECURITY NO: 212-34-8700
17. INFORMANT: Address: CLARENCE DePEW, Port Tobacco, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Pulmonary fibrosis, cause undet. — INTERVAL BETWEEN ONSET AND DEATH: 18 Mos
DUE TO
(b)
DUE TO
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from May, 1967, to Oct 5, 1967, that (I) (we) last saw the deceased alive on Oct 5 1967, and that death occurred at 7 M, from causes and on the date stated above.

22a. SIGNATURE: J. Roy Guyther — M.D. ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED: 10-5-67
22c. PHYSICIAN'S NAME (Type): J. Roy Guyther
22d. ADDRESS: MECHANICSVILLE, MARYLAND

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 10-9-67
23c. NAME OF CEMETERY OR CREMATORY: St Ignatius
23d. LOCATION (City or Town) (County) (State): Hilltop, Charles, Md.

24. FUNERAL DIRECTOR ADDRESS: The Humtt Funeral Home, Waldorf, Md.

25a. REC'D BY REGISTRAR DATE: OCT 11 1967
25b. REGISTRAR'S SIGNATURE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14446

1 PLACE OF DEATH
a. COUNTY: ST. MARY.S — MARYLAND — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): LEONARDTOWN
c. LENGTH OF STAY IN 1b: 2 Mo.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): ST. MARY.S NURSING HOME

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: MARYLAND
b. COUNTY: BALTIMORE
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BALTIMORE Md.
d. STREET ADDRESS: 2405 BIRCH Dr. BALTI. Md.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: MATILDA — Middle: [illegible] — Last: DUNKES

4. DATE OF DEATH: Month: OCTOBER — Day: 18 — Year: 19 67

5. SEX: FEMALE

6. COLOR OR RACE: CAUCASIAN

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 2/19/1884

9. AGE (In years last birthday): 83 yrs

IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE

10b. KIND OF BUSINESS OR INDUSTRY: DOMESTIC

11. BIRTHPLACE (County & State, or foreign country): BALTIMORE MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: GEORGE W. MARSHALL

14. MOTHER'S MAIDEN NAME: LAVANIA L. PRESTON

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)

16. SOCIAL SECURITY NO.: 213-10-6332-A

17. INFORMANT: GEORGE DUNKES — Address: SAME AS #3

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Electrolyt Im Balance — INTERVAL BETWEEN ONSET AND DEATH: 3 mo.
DUE TO (b): Pneumonia + Colitis — 24 hr.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO (c): Degenerative Cardio Vascular Disease

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (~~this hospital~~) attended the deceased from 8/23, 1967, to 10/18, 1967, that (I) (~~we~~) last ~~saw~~ the deceased alive on 10/18 1967 and that death occurred at 11:38 A.M., from causes and on the date stated above.

22a. SIGNATURE: John F. Fenwick — M.D — ATTENDING PHYS. ☒ MED DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 10/19/67

22c. PHYSICIAN'S NAME (Type): JOHN F. FENWICK M. D.

22d. ADDRESS: LEONARDTOWN MARYLAND

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 10/21/67

23c. NAME OF CEMETERY OR CREMATORY: Moreland Memorial

23d. LOCATION (City or Town) (County) (State): Baltimore Md.

24. FUNERAL DIRECTOR: J.T.Stansbury — ADDRESS: 6411 Windsor Mill Rd.

25a. REC'D BY REGISTRAR — DATE: OCT 23 1967

25b. REGISTRAR'S SIGNATURE: [signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

1442

CERTIFICATE OF DEATH

14447

1. PLACE OF DEATH
a. COUNTY: ST. MARY'S — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): LEONARDTOWN,
c. LENGTH OF STAY IN 1b: THREE WEEKS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): ST. MARY'S HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: ST. MARY'S
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BUSHWOOD
d. STREET ADDRESS: RURAL
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First: ELLEN — Middle: LEARY — Last: ELLIS

4. DATE OF DEATH: Month: OCTOBER, Day: 9, Year: 19 67

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

8. DATE OF BIRTH: JAN. 19, 1886

9. AGE (In years last birthday): 81 yrs.
IF UNDER 1 YEAR: Months / Days / Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): WIFE

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): PHILADELPHIA, PENNA.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: CORNELIUS LEARY

14. MOTHER'S MAIDEN NAME: MARGARET GAFFNEY

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: R. CARROLL ELLIS — Address: BUSHWOOD, MARYLAND

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Embolism — INTERVAL BETWEEN ONSET AND DEATH: 2 days
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b) Auricular Fibrillation converted — 1 wk
DUE TO
(c) Arteriosclerotic Heart Disease — 10+ years

PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES [ ] NO [ ]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work [ ] Not While at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from _____, 19___, to _____, 19___, that (I) (we) last saw the deceased alive on _____ 19___, and that death occurred at _____ M, from causes and on the date stated above.

22a. SIGNATURE: John F. Fenwick M.D. — ATTENDING PHYS [X] MED. DIRECTOR [ ] STAFF PHYS [ ]

22b. DATE SIGNED: 10.10.67

22c. PHYSICIAN'S NAME (Type): JOHN F. FENWICK M. D.

22d. ADDRESS: LEONARDTOWN, MARYLAND

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: Oct. 11, 1967

23c. NAME OF CEMETERY OR CREMATORY: SACRED HEART CEMETERY

23d. LOCATION (City or Town) (County) (State): BUSHWOOD, ST. MARY'S, MD.

24. FUNERAL DIRECTOR — ADDRESS: W. CLARKE MATTINGLEY — LEONARDTOWN, MARYLAND

25a. RECD BY REGISTRAR DATE: OCT 16 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18, give Pages 1, 2, and 3 to the funeral director Page 4 should be forwarded to the Chief Medical Examiner's Office along with Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14542

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14418

1 PLACE OF DEATH
a. COUNTY: St. Mary's — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): NAS, Patuxent River
c. LENGTH OF STAY IN 1b: 45 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Station Hospital

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Kentucky — b. COUNTY: Kenton
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Erlanger
d. STREET ADDRESS: 422 Sunset Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: Cletus — Middle: John — Last: Fisk

4 DATE OF DEATH: Month: October — Day: 23, — Year: 19 67

5 SEX: male

6 COLOR OR RACE: caucasian

7 MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8 DATE OF BIRTH: June 17, 1948

9 AGE (In years last birthday): 19 yrs

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b KIND OF BUSINESS OR INDUSTRY: U. S. Navy

11. BIRTHPLACE (State or foreign country): Kentucky

12 CITIZEN OF WHAT COUNTRY? U.S.

13 FATHER'S NAME: Cletus L. Fisk

14. MOTHER'S MAIDEN NAME: Eunice Anette Bain

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): yes MAY '67 to OCT '67

16 SOCIAL SECURITY NO: 406-64-6888

17 INFORMANT — Address: Official U. S. Navy Records.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a): Subdural hematoma
DUE TO
(b): Basal skull fracture
DUE TO
(c):
Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last: 1 3 4

INTERVAL BETWEEN ONSET AND DEATH

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH

20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18): Fall from moving government jeep. (passenger)

20c TIME OF INJURY Month, Day, Year Hour a.m. p.m.: 1900 Oct. 23, 19 67

20d INJURY OCCURRED While at work ☐ Not While at work ☒

20e PLACE OF INJURY (Home, farm factory, street office bldg. etc.): Naval Facility

20f (City or town) (County) (State): Ridge, St. Mary's, Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from Natural causes ☐, Accident ☑, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: J. J. Witowski J. J. WITOWSKI, LT, MC, USN MD

EXAMINER'S NAME (Type): Wm D Boyd MD WILLIAM D BOYD

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

Address (Street, city, town, or county)

22. DATE SIGNED: October 23, 1967

23a BURIAL CREMATION, REMOVAL (Specify): TRANSIT

23b DATE THEREOF: 10/25/67

23c NAME OF CEMETERY OR CREMATORY

23d LOCATION (City or Town) (County) (State): ERLANGER, KY.

24a FUNERAL DIRECTOR: John M Welch — ADDRESS: JOHN M. WELCH - LEONARDTOWN, MD.

25a REC'D BY REGISTRAR DATE: OCT 30 1967

25b REGISTRAR'S SIGNATURE: J Charles Judge

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If an autopsy is necessary, please execute certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
5M 1/62

14449

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1443

1. PLACE OF DEATH
a. COUNTY: ST MARY'S
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): NEAR PINEY POINT
c. LENGTH OF STAY IN 1b: MARYLAND N/A
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): POTOMAC RIVER

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: VIRGINIA
b. COUNTY: NEWPORT NEWS
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): FORT EUSTIS
d. STREET ADDRESS: 1106-B THOMPSON CIR.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First WILLIAM Middle JAY Last FRANCIS
4. DATE OF DEATH: Month OCTOBER Day 10 Year 19 67
5. SEX: MALE
6. COLOR OR RACE: CAU
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 25 FEB 33
9. AGE (In years last birthday): 34 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): ARMY AVAITOR
10b. KIND OF BUSINESS OR INDUSTRY: U.S. ARMY
11. BIRTHPLACE (State or foreign country): NEWPORT NEWS, VIRGINIA
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: MORGAN B. FRANCIS
14. MOTHER'S MAIDEN NAME: VIOLET JONES
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes give war or dates of service): 15 JAN 57-Pres.
16. SOCIAL SECURITY NO: 229362754
17. INFORMANT: U.S.ARMY RECORDS Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a) (b), and (c)]

PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a): Severe open crushing head injury with brain laceration and contusion assoicated with
DUE TO (b): laceration and rupture of heart associated with
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO (c): aircraft accident

INTERVAL BETWEEN ONSET AND DEATH: INSTANT

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Multiple fractures of extremities;crushing chest injuries

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☒ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.): Forces of sudden decelleration when aircraft crashed
20c. TIME OF INJURY Month, Day, Year Hour a.m. 10:45 xx. Oct 10 19 67
20d. INJURY OCCURRED While at work ☒ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Airplane
20f. (City or town) (County) (State): Potomac River St Mary's Md.

21 I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry [redacted] and in my opinion death resulted from Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: Wm D Boyd MD
EXAMINER'S NAME (Type): WILLIAM D. BOYD, MD
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county):
DATE SIGNED: OCT 13, 1967

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Oct 18,1967
22c. NAME OF CEMETERY OR CREMATORY: Arlington National
22d. LOCATION (City, town, or county) (State): Virginia

23. FUNERAL DIRECTOR: Howard County Funeral Home of Harry Witzke
ADDRESS: Ellicott City, Md

24a. REC'D BY REGISTRAR DATE NOV 15 1967
24b. REGISTRAR'S SIGNATURE

[illegible] JOINTLY REPORTED ON [illegible] DEATH CERTIFICATE AND SHOULD
[illegible] [illegible] M.E.

[illegible] 6394 - 11/15/67 mnb

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12444

14450

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH
a COUNTY: St Mary's — MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): NEAR PINEY POINT
c LENGTH OF STAY IN 1b: N/A
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): POTOMAC RIVER

2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission)
a STATE: VIRGINIA
b COUNTY: NEWPORT NEWS
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): DENBIGH
d STREET ADDRESS: 106 TRAILUX MOBILE VIL.
e IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ROGER — Middle CLINTON — Last FULTZ
4 DATE OF DEATH: Month OCTOBER — Day 10 — Year 19 67

5 SEX: MALE
6 COLOR OR RACE: CAU
7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8 DATE OF BIRTH: 19 AUG 39
9. AGE (In years last birthday): 28 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min.

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): FLIGHT ENGINEER
10b KIND OF BUSINESS OR INDUSTRY: U.S.ARMY
11. BIRTHPLACE (State or foreign country): NASHVILLE, TENN
12 CITIZEN OF WHAT COUNTRY? USA

13 FATHER'S NAME: SAM C. FULTZ
14. MOTHER'S MAIDEN NAME: UNKNOWN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): YES (If yes give war or dates of service): 4 Jun62-Pres
16. SOCIAL SECURITY NO: 409583585
17 INFORMANT: U.S.ARMY RECORDS — Address

MED. CA. CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a) (b), and (c).)
PART I DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Severe open crushing head injury with brain
DUE TO (b): lacertation and rupture of heart and contusion
Conditions if any which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c): associated with the brain laceration associated with aircraft accident.
INTERVAL BETWEEN ONSET AND DEATH: INSTANT

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Multiple fractures of extremities, crushing chest injuries
19 WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☒ CAUSE OF DEATH.
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18): Forces of sudden decelleration when aircraft crashed
20c TIME OF INJURY Month, Day, Year: 10:45 Hour a.m. xxxx Oct 10 '67
20d INJURY OCCURRED While at work ☒ Not While at work ☐
20e PLACE OF INJURY (Home, farm factory, street, office bldg., etc.): Aircraft
20f. (City or town) (County) (State): Potomac River StMary's Md

21. I **certify** that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Wm D Boyd M.D
EXAMINER'S NAME (Type): WILLIAM D. BOYD, MD
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county):
22. DATE SIGNED: 13 OCT 67

23a BURIAL, CREMATION, REMOVAL (Specify): Burial
23b DATE THEREOF: Oct 18, 1967
23c NAME OF CEMETERY OR CREMATORY: Arlington National
23d LOCATION (City or Town) (County) (State): Virginia

24. FUNERAL DIRECTOR: HOWARD COUNTY FUNERAL HOME OF Harry Witzke
ADDRESS: Ellicott City, Md
25a REC'D BY REGISTRAR DATE: NOV 15 1967
25b REGISTRAR'S SIGNATURE: [signature]

VR A15ME (5)
6M 1/67

IGINALLY REPORTED ON REGULAR FORM AND SHOULD BE M.E.
FILM G 394 - 11/15/67 - mnb

8 1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

4445 — 14451

1 PLACE OF DEATH
a. COUNTY: St. Mary's — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): NAS, Patuxent River
c. LENGTH OF STAY IN 1b: 03 yrs. 11 mo.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Station Hospital

2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: St. Mary's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hollywood
d. STREET ADDRESS: Rt. #2, Box 280
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print) First	Middle	Last	4 DATE OF DEATH Month	Day	Year
Marion	August	Greenwell	October	16,	19 67

5 SEX	6 COLOR OR RACE	7 MARRIED ☒ / NEVER MARRIED ☐ / WIDOWED ☐ / DIVORCED ☐	8 DATE OF BIRTH	9 AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min
male	caucasian		Nov. 28, 1923	43 yrs		

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b KIND OF BUSINESS OR INDUSTRY	11 BIRTHPLACE (State or foreign country)	12 CITIZEN OF WHAT COUNTRY?
Aviation Metalsmith	U. S. Navy	Indiana	U2S.

13 FATHER'S NAME	14 MOTHER'S MAIDEN NAME
August M. Greenwell (deceased)	Lillian King (deceased)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16. SOCIAL SECURITY NO.	17 INFORMANT Address
yes 13NOV42-16OCT67	265-06-0301	Official U. S. Navy Records

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

PART I DEATH WAS CAUSED BY — INTERVAL BETWEEN ONSET AND DEATH

8164

IMMEDIATE CAUSE (a): Rupture, liver, massive with interabdominal — Immediate

DUE TO: exsanguination.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b): Automobile accident.

DUE TO

(c):

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH

20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18): Auto accident. Head-on collision.

20c TIME OF INJURY Month, Day, Year Hour a.m.	20d INJURY OCCURRED While at work ☐ / Not While at work ☒	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
10:50pm Oct. 16, 67		Street, Rt.235	Hollywood St. Mary's Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: J. SONSINE, LT., MC, USN M.D

EXAMINER'S NAME (Type): WILLIAM D BOYD

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

22 DATE SIGNED: October 16, 1967

Address (Street, city, town or county)

22a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE THEREOF	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION (City or Town) (County) (State)
BURIAL	10/20/67	ARLINGTON NATL. CEM.	ARLINGTON, VA.

24 FUNERAL DIRECTOR ADDRESS: JOHN M. WELCH — LEONARDTOWN, MD.

25a REC'D BY REGISTRAR DATE: OCT 23 1967

25b REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13445

CERTIFICATE OF DEATH

14452

1. PLACE OF DEATH — a. COUNTY: ST. MARY'S — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): LEONARDTOWN
c. LENGTH OF STAY IN 1b: 5 WEEKS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): ST. MARY'S Hosp

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) — a. STATE: MARYLAND — b. COUNTY: ST. MARY'S
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CLEMENTS
d. STREET ADDRESS: RURAL
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First: FLORENCE — Middle: LATHAM — Last: GUY
4. DATE OF DEATH: Month: OCTOBER — Day: 9, — Year: 1967

5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]
8. DATE OF BIRTH: Nov. 19, 1883
9. AGE (In years last birthday): 83 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSE WIFE
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: ENDERS LATHAM
14. MOTHER'S MAIDEN NAME: HELEN MARAN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service):
16. SOCIAL SECURITY NO: 220-34-8277
17. INFORMANT: ALBERTA G. GUY — Address: RT. 2 LEONARDTOWN, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Carcinoma of rectum
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b):
DUE TO
(c):
154x
INTERVAL BETWEEN ONSET AND DEATH: 2 months

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [ ]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work [ ] Not While at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Aug, 1967, to Oct 9, 1967, that (I) (we) last saw the deceased alive on Oct 8 1967, and that death occurred at 3 P M, from causes and on the date stated above.

22a. SIGNATURE: W D Boyd M.D — ATTENDING PHYS [X] MED. DIRECTOR [ ] STAFF PHYS [ ]
22b. DATE SIGNED: 10/11/67
22c. PHYSICIAN'S NAME (Type): WILLIAM D. BOYD M. D.
22d. ADDRESS: LEONARDTOWN, MARYLAND

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: Oct. 22, 1967
23c. NAME OF CEMETERY OR CREMATORY: ST. ALOYSIUS CEMETERY
23d. LOCATION (City or Town) (County) (State): LEONARDTOWN, ST. MARY'S, MD.

24. FUNERAL DIRECTOR — ADDRESS: W. CLARKE MATTINGLEY LEONARDTOWN, MARYLAND
25a. REC'D BY REGISTRAR DATE: OCT 17 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14453

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE HEALTH DEPT.

1 PLACE OF DEATH
a. COUNTY: St MARY'S — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): NEAR PINEY POINT
c. LENGTH OF STAY IN 1b: N/A
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): POTOMAC RIVER

2 USUAL RESIDENCE (Where deceased lived if institution, Residence before admission)
a. STATE: VIRGINIA
b. COUNTY: NEWPORT NEWS
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): NEWPORT NEWS
d. STREET ADDRESS: 69 REXFORD DR.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First MARVIN; Middle LeVAN; Last JOHNSON
4. DATE OF DEATH: Month OCTOBER; Day 10; Year 1967

5 SEX	6 COLOR OR RACE	7 MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	8 DATE OF BIRTH	9 AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS Hours	Min
MALE	CAU	7 MARRIED ☒	11 JAN 37	30 yrs				

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b KIND OF BUSINESS OR INDUSTRY	11 BIRTHPLACE (State or foreign country)	12 CITIZEN OF WHAT COUNTRY?
ARMY AVIATOR	U.S.ARMY	CLAYTON, N.C.	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
LEWIS BRAXTON JOHNSON	ANNIE LOUISE STEPHENSON

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address
Yes	17Mar59-Pres	242522790	U.S.ARMY

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Severe open crushing head injury with brain
DUE TO (b): laceration and contusion and rupture of heart
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
INTERVAL BETWEEN ONSET AND DEATH: INSTANT

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Multiple fractures of extremities, crushing chest injuries
19 WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☒ CAUSE OF DEATH
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18): Forces of sudden decelleration when aircraft crashed

20c TIME OF INJURY Month, Day, Year Hour a.m. p.m.	20d INJURY OCCURRED While at work ☒ / Not While at work ☐	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
10:45 EST Oct 10 19 67	While at work ☒	Airplane	Potomac River, St Mary's, Md

21. I certify that I took charge of the remains described above, held on Autopsy ☒, Inspect on ☒, Inquiry ☒, and in my opinion death resulted from Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: William D. Boyd M.D.
EXAMINER'S NAME (Type): WILLIAM D. BOYD, MD
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county)
22. DATE SIGNED: OCT 13,1967

23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE THEREOF	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION (City or Town) (County) (State)
Burial	October 19,1967	Arlington National	Virginia

24 FUNERAL DIRECTOR	ADDRESS	25a REC'D BY REGISTRAR DATE	25b REGISTRAR'S SIGNATURE
HOWARD COUNTY FUNERAL Home of Harry Witzke	Ellicott City, Md	NOV 15 1967	Charles Judge

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

ORIGINALLY REPORTED ON REGULAR DEATH CERTIFICATE AS SHOULD HAVE BEEN M.E.

FBI 6394 - 11/15/67 mnb

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11448

14454

CERTIFICATE OF DEATH

1. PLACE OF DEATH
a. COUNTY: St. Mary's — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Leonardtown
c. LENGTH OF STAY IN 1b: XXXXXX.1 HOUR
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): St. Mary's Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Maryland — b. COUNTY: St. Mary's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Lexington Park
d. STREET ADDRESS: 54 Salamaua Court
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: John — Middle: Andrews — Last: King

4. DATE OF DEATH: Month: October — Day: 12, — Year: 19 67

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: June 5, 1894

9. AGE (In years last birthday): 73 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Civil Service

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State or foreign country): Washington, D.C.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: James O. King

14. MOTHER'S MAIDEN NAME: XXXXXXXXXXXXXX Chandler

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service):

16. SOCIAL SECURITY NO.: 231-05-1417A

17. INFORMANT: Florence B. King — Address: same as # 2 above

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Acute Myocardial Infarction
DUE TO (b): Arteriosclerosis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO (c):
INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour o'clock a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 10-12, 19 67 to 10-12-67, 19___, that (I) (we) last saw the deceased alive on 10-12-67 at 9:45 a.m. and that death occurred at 10:45 a.m., from causes and on the date stated above.

22a. SIGNATURE: Michael Barbarich M.D. — ATTENDING PHYS ☐ MED DIRECTOR ☐ STAFF PHYS ☐

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): Michael Barbarich M. D.

22d. ADDRESS: Leonardtown, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Oct. 16, 1967

23c. NAME OF CEMETERY OR CREMATORY: Trinity Memorial Gardens

23d. LOCATION (City or Town) (County) (State): Waldorf, Charles, Maryland

24. FUNERAL DIRECTOR: W. Clarke Mattingley — ADDRESS: Leonardtown, Maryland

25a. RECD BY REGISTRAR DATE: OCT 17 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14449

CERTIFICATE OF DEATH

14455

1 PLACE OF DEATH
a. COUNTY: St. Mary's — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): LEONARDTOWN
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): St. Mary's Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: St. Mary's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): LEXINGTON PARK
d STREET ADDRESS: RURAL
e IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
WILLIE		LEWIS	OCTOBER	24,	19 67

5. SEX	6 COLOR OR RACE	7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min
MALE	NEGRO		FEB. 16, 1900	67 yrs				

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11 BIRTHPLACE (County & State, or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		NORTH CAROLINA	U.S.A.

13 FATHER'S NAME	14. MOTHER'S MAIDEN NAME
? ? ?	? ? ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT Address
		BESSIE WADE RT. 1 Box B22 FOREST HEIGHTS, MARYLAND

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY.

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Circulatory Collapse	4 min.
DUE TO (b)	Ventricular Fibrillation	mins.
DUE TO (c)	Myocardial Infarction	mins

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d INJURY OCCURRED While at work ☐ Not While at work ☐	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)

21. I certify that (I) ~~(the hospital)~~ attended the deceased from Sept, 19 67 to Oct, 19 67, that (I) ~~(we)~~ last saw the deceased alive on Oct 24, 19 67 and that death occurred at 2:20 P.M. from causes and on the date stated above

22a SIGNATURE	ATTENDING PHYS. ☒ MED DIRECTOR ☐ STAFF PHYS ☐	22b. DATE SIGNED
James P. Jarboe M.D.		10/25/67

22c. PHYSICIAN'S NAME (Type)	22d. ADDRESS
JAMES P. JARBOE M. D.	GREAT MILLS, MARYLAND

23a BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
BURIAL	OCT. 30, 1967	ST. ALOYSIUS	LEONARDTOWN, ST. MARY'S, MD.

24. FUNERAL DIRECTOR ADDRESS	25a REC'D BY REGISTRAR DATE	25b REGISTRAR'S SIGNATURE
W. CLARKE MATTINGLEY LEONARDTOWN, MD.	OCT 27 1967	Charles Judge

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14450

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14456

1. PLACE OF DEATH
a. COUNTY: St. Mary's — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): USNAS, Patuxent River
c. LENGTH OF STAY IN 1b: 07 mos. 06 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Station Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Maryland
b. COUNTY: St. Mary's ✓
c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Lexington Park, Maryland
d. STREET ADDRESS: 130 Chinlee Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: William — Middle: Joseph — Last: Link Jr.

4. DATE OF DEATH: Month: October — Day: 9, — Year: 1967

5. SEX: male

6. COLOR OR RACE: caucasian

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: March 4, 1967

9. AGE (In years last birthday) yrs — IF UNDER 1 YEAR: Months 7, Days 6 — IF UNDER 24 HRS: Hours, Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): U.S.Naval Hospital, Memphis, Tennessee

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: William Joseph Link Sr.

14. MOTHER'S MAIDEN NAME: Elizabeth Louise Boisclair

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)

16. SOCIAL SECURITY NO

17. INFORMANT — Address: William J. Link, Sr. same as #2, c & d.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Asphyxiation — INTERVAL BETWEEN ONSET AND DEATH
DUE TO
(b)
DUE TO
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
240

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.): Found not breathing in baby's crib.

20c. TIME OF INJURY Month, Day, Year: 10:33 Hour a.m. p.m. OCT. 9, 1967

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg. etc.): Home.

20f. (City or town) (County) (State): Lexington Pk. St. Mary's, Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: LT C.E. MACCARTHY, MC, USN — MD
EXAMINER'S NAME (Type): WILLIAM D BOYD MD
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county)

22. DATE SIGNED: 10/11/67

23a. BURIAL CREMATION, REMOVAL (Specify): TRANSIT

23b. DATE THEREOF: 10/11/67

23c. NAME OF CEMETERY OR CREMATORY

23d. LOCATION (City or Town) (County) (State): T ROY, NEW YORK

24. FUNERAL DIRECTOR: JOHN M. WELCH — LEONARDTOWN, MARYLAND — ADDRESS

25a. RECD BY REGISTRAR: DA OCT 16 1967

25b. REGISTRAR'S SIGNATURE: Gillian Judge

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/68

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14451

CERTIFICATE OF DEATH

14457

1. PLACE OF DEATH
a. COUNTY: ST. MARY,S — MARYLAND — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): LEONARDTOWN
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): ST. MARY,S NURSING HOME

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ST. MARY,S
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL MADDOX Md.
d. STREET ADDRESS: RURAL MADDOX Md.
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First AGNES — Middle RUSSELL — Last LYON

4. DATE OF DEATH: Month OCTOBER — Day 2 — Year 1967

5. SEX: FEMALE

6. COLOR OR RACE: CAUCASIAN

7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]

8. DATE OF BIRTH: 1/31/1890

9. AGE (In years last birthday): 77 yrs

If UNDER 1 YEAR: Months — Days
If UNDER 24 HRS: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE

10b. KIND OF BUSINESS OR INDUSTRY: DOMESTIC

11. BIRTHPLACE (County & State, or foreign country): MARYLAND ST. MARY,S

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: FRANK RUSSELL

14. MOTHER'S MAIDEN NAME: EMILY CULLISON

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO
(If yes give war or dates of service):

16. SOCIAL SECURITY NO.: 579-5044-78

17. INFORMANT: WEST RUSSELL LYON — Address: MADDOX Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Carcinoma - ovary with
DUE TO
(b): metastases
DUE TO
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
1750

INTERVAL BETWEEN ONSET AND DEATH: 1 yr

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work [ ] Not While at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Mar, 1960, to Oct 2, 1967 that (I) (we) last saw the deceased alive on Oct 1 1967, and that death occurred at ~~P~~ M, from causes and on the date stated above.

22a. SIGNATURE: J Roy Guyther M.D. — ATTENDING PHYS. [X] MED DIRECTOR [ ] STAFF PHYS. [ ]

22b. DATE SIGNED: 10/3/1967

22c. PHYSICIAN'S NAME (Type): J. ROY GUYTHER M.D.

22d. ADDRESS: MECHANICSVILLE Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 10/4/1967

23c. NAME OF CEMETERY OR CREMATORY: CHRIST CHURCH CEM.

23d. LOCATION (City or Town) (County) (State): CHAPTICO ST. MARY,S Md.

24. FUNERAL DIRECTOR: JOHN T. WELCH — ADDRESS: LEONARDTOWN MARYLAND

25a. REC'D BY REGISTRAR DATE OCT 9 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

4452 — 14458

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH
a. COUNTY: St. Mary's — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Leonardtown
c. LENGTH OF STAY IN 1b: 6 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): St. Mary's Hospital

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Maryland — b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Federalsburg
d. STREET ADDRESS: Greenridge Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3 NAME OF DECEASED (Type or print): First: Minnie — Middle: Rebecca — Last: Mills

4 DATE OF DEATH: Month: October — Day: 22, — Year: 19 67

5. SEX: Female
6. COLOR OR RACE: White
7 MARRIED ☐ NEVER MARRIED ☐ WIDOWED XX DIVORCED ☐
8. DATE OF BIRTH: April 12, 1891
9 AGE (In years last birthday): 76 yrs
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework
10b KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (County & State, or foreign country): Caroline County, Md.
12 CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William Andrews
14. MOTHER'S MAIDEN NAME: Sarah E. Baker

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)
16. SOCIAL SECURITY NO: 213-01-5027
17. INFORMANT: Address: Mrs Joseph D. Weiner Leonardtown, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a): Uremia — INTERVAL BETWEEN ONSET AND DEATH: 2 days
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): arterio sclerotic cardio vascular renal disease — 10 yrs
DUE TO
(c):

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19
20d INJURY OCCURRED While at work ☐ Not While at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from July, 19 67, to Oct 22, 19 67, that (I) (we) last saw the deceased alive on Oct 21 19 67, and that death occurred at 1246 PM, from causes and on the date stated above.

22a. SIGNATURE: Jno D Boyd M.D. — ATTENDING PHYS ☑ MED DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED: 10/22/67
22c PHYSICIAN'S NAME (Type): William D. Boyd M. D.
22d ADDRESS: Leonardtown, Maryland

23a BURIAL, CREMATION, REMOVAL (Specify): Burial
23b DATE THEREOF: Oct. 24, 1967
23c. NAME OF CEMETERY OR CREMATORY: Hill Crest Cemetery
23d LOCATION (City or Town) (County) (State): Federalsburg, Maryland

24 FUNERAL DIRECTOR — ADDRESS: J. J. Framptom and Son, Federalsburg, Md.
25a. REC'D BY REGISTRAR DATE: OCT 27 1967
25b. REGISTRAR'S SIGNATURE: Charles Jones

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14453

CERTIFICATE OF DEATH

14459

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 20 M 1/66

1 PLACE OF DEATH
a. COUNTY: ST. MARY'S — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): LEONARDTOWN
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): ST. MARY'S HOSPITAL

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ST. MARY'S
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL MECHANICSVILLE
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3 NAME OF DECEASED (Type or print): First WILLIAM Middle FRANCIS Last NOLAN

4 DATE OF DEATH: Month 10 Day 19 Year 19 67

5 SEX: MALE

6 COLOR OR RACE: NEGRO

7 MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

8 DATE OF BIRTH: 10 - 16- 1904

9 AGE (In years last birthday): 62 yrs

IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min.

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): FARMER

10b KIND OF BUSINESS OR INDUSTRY: TENANT FARMING

11 BIRTHPLACE (County & State, or foreign country): MARYLAND

12 CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: ARTHUR NOLAN

14. MOTHER'S MAIDEN NAME: LUCY BUTLER

15 WAS DECEASED EVER IN U.S ARMED FORCES? (Yes, no, or unknown) NO (If yes give war or dates of service)

16 SOCIAL SECURITY NO.: 214-36-2921

17. INFORMANT: MRS. LEONA MARIE NOLAN Address: MECH., MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))
PART I DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Pulmonary embolus — INTERVAL BETWEEN ONSET AND DEATH: 2 months
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b):
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Arteriosclerosis, rheumatoid, gout

19 WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d INJURY OCCURRED While at work [ ] Not While at work [ ]

20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from July, 1966, to Oct 19, 1967, that (I) (we) last saw the deceased alive on Oct 18 1967, and that death occurred at 7A M, from causes and on the date stated above.

22a SIGNATURE: Roy Guyther M.D. ATTENDING PHYS [X] MED. DIRECTOR [ ] STAFF PHYS [ ]

22b DATE SIGNED: 10/20/67

22c. PHYSICIAN'S NAME (Type): J. ROY GUYTHER M.D.

22d ADDRESS: MECHANICSVILLE Md.

23a BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 10/21/67

23c. NAME OF CEMETERY OR CREMATORY: ST. JOHN'S CEMETERY

23d LOCATION (City or Town) (County) (State): HOLLYWOOD, MARYLAND

24. FUNERAL DIRECTOR: JOHN M. WELCH ADDRESS: LEONARDTOWN, MD.

25a RECD BY REGISTRAR DATE: OCT 24 1967

25b. REGISTRAR'S SIGNATURE: [illegible]

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14454 14460

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH
a. COUNTY: St Mary's — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): NEAR PINEY POINT
c. LENGTH OF STAY IN 1b: N/A
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): POTOMAC RIVER

2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: VIRGINIA
b. COUNTY: NEWPORT NEWS
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): FORT EUSTIS
d. STREET ADDRESS: 2302-B JACKSON AVE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: JAMES — Middle: P.(IO) — Last: PERRY

4 DATE OF DEATH: Month: OCTOBER — Day: 10 — Year: 19 67

5 SEX: MALE

6 COLOR OR RACE: CAU

7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8 DATE OF BIRTH: 5 MAY 37

9 AGE (In years last birthday): 30 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min.

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): ARMY AVIATOR

10b KIND OF BUSINESS OR INDUSTRY: U.S. ARMY

11. BIRTHPLACE (State or foreign country): DECLO(CASSIA) IDAHO

12 CITIZEN OF WHAT COUNTRY?: USA

13 FATHER'S NAME: JOSEPH FRANCIS PERRY

14. MOTHER'S MAIDEN NAME: ALICE BIGLER

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): YES (If yes give war or dates of service): 10 JUL 62-Pres

16. SOCIAL SECURITY NO.: 528505661

17. INFORMANT: U.S.ARMY RECORDS — Address:

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a) (b) and (c))
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Severe open crushing head injury with brain
DUE TO (b): laceration and contusion associated with
Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO (c): laceration and rupture of heart associated with aircraft accident.

INTERVAL BETWEEN ONSET AND DEATH: INSTANT

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Multiple fractures of extremities; crushing chest injuries

19 WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☒ CAUSE OF DEATH

20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18): Forces of sudden decelleration on impact of airplane

20c TIME OF INJURY Month, Day, Year Hour a.m. p.m.: 10:45 PM Oct 10 19 67

20d INJURY OCCURRED While at work ☒ Not While at work ☐

20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Aircraft

20f. (City or town) (County) (State): Potomac River, St Mary's, Md

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: A D Boyd MD — M.D.

EXAMINER'S NAME (Type): WILLIAM D. BOYD, MD

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

Address (Street, city, town, or county):

22. DATE SIGNED: 13 OCT 67

23a BURIAL, CREMATION, REMOVAL (Specify): Burial

23b DATE THEREOF: Oct 16, 1967

23c NAME OF CEMETERY OR CREMATORY: Wilford Cemetery

23d LOCATION (City or Town) (County) (State): Rexburg, Idaho

24. FUNERAL DIRECTOR: HOWARD COUNTY FUNERAL HOME of Harry Witzke

ADDRESS: Ellicott City, Md

25a. RECD BY REGISTRAR DATE: NOV 15 1967

25b. REGISTRAR'S SIGNATURE: Wanda Yingst

VR A15ME (5)
6M 1/67

ORIGINALLY REPORTED ON REGULAR DEATH CERTIFICATE AND SHOULD HAVE BEEN ON M.E.

FILM G394 - 11/15/67 mnb

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

7655 — 14461

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 20 M 1/68

1. PLACE OF DEATH a. COUNTY: ST. MARY,S — MARYLAND MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): LEONARDTOWN c. LENGTH OF STAY IN 1b: d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): ST. MARY,S HOSPITAL	2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE: MARYLAND — b. COUNTY: ST. MARY,S c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): (RURAL) SCOTLAND d. STREET ADDRESS: SCOTLAND MARYLAND e. IS RESIDENCE ON A FARM? YES [X] NO [ ]
3. NAME OF DECEASED (Type or print): First CLARENCE — Middle HOZIDAR — Last RIDGELL	4. DATE OF DEATH: Month OCTOBER — Day 16 — Year 1967
5. SEX: MALE	6. COLOR OR RACE: CAUC
7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	8. DATE OF BIRTH: 2-14-1889
9. AGE (In years last birthday): 78 yrs	IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): FARMING	10b. KIND OF BUSINESS OR INDUSTRY: FARMER
11. BIRTHPLACE (County & State, or foreign country): MARYLAND ST. MARY,S	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: AUSTIN RIDGELL	14. MOTHER'S MAIDEN NAME: REBECCA HAMMETT
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO — (If yes give war or dates of service)	16. SOCIAL SECURITY NO.: 212-24-2784
17. INFORMANT: HATTIE L. RIDGELL — Address: SCOTLAND MARYLAND	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a): Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: 4 days
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Generalized arteriosclerosis — 6 years
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Cerebral embolism

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work [ ] Not While at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I **certify** that (I) (this hospital) attended the deceased from May 28, 1967, to Oct 16, 1967, that (I) (we) last saw the deceased alive on Oct 16 1967, and that death occurred at 10P M, from causes and on the date stated above.

22a. SIGNATURE: P J Bean M.D. — ATTENDING PHYS [X] MED. DIRECTOR [ ] STAFF PHYS. [ ] — 22b. DATE SIGNED: 10/17/67

22c. PHYSICIAN'S NAME (Type): P. J. BEAN M.D. — 22d. ADDRESS: GREAT MILLS MARYLAND

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
BURIAL	10/19/1967	ST. MICHAEL,S CEM.	RIDGE ST. MARY,S Md.

24. FUNERAL DIRECTOR: John M. Welch — ADDRESS: JOHN M. WELCH LEONARDTOWN MARYLAND

25a. REC'D BY REGISTRAR DATE: OCT 23 1967 — 25b. REGISTRAR'S SIGNATURE: Charles Dukes

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Dr Wm D Boyd
St Mary's County, Md.
Medical examiner notified and approved

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14458

CERTIFICATE OF DEATH

14462

1. PLACE OF DEATH
a. COUNTY: ST. MaRY'S — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): PaTUXENT
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): STATION HOSPITAL NAS PaTUXENT RIVER,MD

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ST. MARY'S
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hollywood, Md.
d. STREET ADDRESS: Rt#2 Box144L
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First FRANCIS Middle F. Last SMITH

4. DATE OF DEATH: Month OCT Day 8 Year 19 67

5. SEX: M

6. COLOR OR RACE: Cau

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Jan 22, 1906

9. AGE (In years last birthday): 61 yrs.

IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Director of vehicles

10b. KIND OF BUSINESS OR INDUSTRY: Post Office

11. BIRTHPLACE (County & State or foreign country): Washington D C

12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: Joseph E Smith

14. MOTHER'S MAIDEN NAME: Myrtle E Chapik

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes give war or dates of service): W W 11

16. SOCIAL SECURITY NO.: 578 07 4700

17. INFORMANT: NAMA. M. SMITH Address: Same as #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Abdominal Aortic Aneurism
45 1/x
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO (c):
INTERVAL BETWEEN ONSET AND DEATH

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 10-8-67, 19, to 10-8-67, 19, that (I) (we) last saw the deceased alive on 10-8-67 19, and that death occurred at 2000 M. from causes and on the date stated above

22a. SIGNATURE: George L. Vukmer M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 10-8-67

22c. PHYSICIAN'S NAME (Type): G. J. VUKMER LT MC USN

22d. ADDRESS: STATION HOSPITAL PAX RIVER MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Oct 12, 1967

23c. NAME OF CEMETERY OR ~~CREMATORY~~: Glenwood Cemetery

23d. LOCATION (City or Town) (County) (State): Washington D. C.

24. FUNERAL DIRECTOR: F. Gasch's Sons ADDRESS: Hyattsville, Md.

25a. RECD BY REGISTRAR DATE: OCT 11 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14457

CERTIFICATE OF DEATH

14464

1 PLACE OF DEATH
a. COUNTY: St. Mary's — MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): LEONARDTOWN
c LENGTH OF STAY IN 1b: 6 DAYS
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): St. Mary's Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a STATE: MARYLAND — b. COUNTY: St. Mary's
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): COLTON POINT
d STREET ADDRESS:
e IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: THOMAS — Middle: EDWARD — Last: SWANN
4 DATE OF DEATH: Month: OCTOBER — Day: 8, — Year: 19 67

5 SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8 DATE OF BIRTH: JUNE 21, 1886
9 AGE (In years last birthday): 81 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): FARMING
10b KIND OF BUSINESS OR INDUSTRY:
11 BIRTHPLACE (County & State, or foreign country): MARYLAND
12 CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: PHILIP BRISCOE SWANN
14. MOTHER'S MAIDEN NAME: CLEO HATTON HERBERT

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service):
16. SOCIAL SECURITY NO: 578-40-8084
17. INFORMANT: Address: MRS OLGA S. HAMER — HUGHESVILLE, MARYLAND

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 1 week
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b):
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Senile dementia

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21 I certify that (I) (this hospital) attended the deceased from Oct 10, 1962 to Oct 8, 1967, that (I) (we) last saw the deceased alive on Oct 6 1967, and that death occurred at ____ M, from causes and on the date stated above

22a. SIGNATURE: Roy Guyther — M.D. ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 10-10-67
22c. PHYSICIAN'S NAME (Type): J. ROY GUYTHER M.D.
22d. ADDRESS: MECHANICSVILLE, MARYLAND

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: OCT. 11, 1967
23c. NAME OF CEMETERY OR CREMATORY: CEDAR HILL CEMETERY
23d LOCATION (City or Town) (County) (State): SUITLAND, PRINCE GEORGE, MD.

24 FUNERAL DIRECTOR: W. CLARKE MATTINGLEY
ADDRESS: LEONARDTOWN, MARYLAND
25a. REGISTRAR DATE: OCT 16 1967
25b REGISTRAR'S SIGNATURE: Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14458 (M) 14465

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1. PLACE OF DEATH
a. COUNTY: St. Mary's — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): LEONARDTOWN
c. LENGTH OF STAY IN 1b: 1 DAY
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): St. Mary's Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: St. Mary's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL AVENUE
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: ELIZABETH Middle: R. Last: THOMAS

4. DATE OF DEATH: Month: OCTOBER Day: 7. Year: 1967

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: FEB. 5, 1885

9. AGE (In years last birthday): 82 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSE WIFE

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: JOSEPH OLLIE LONG

14. MOTHER'S MAIDEN NAME: MARY ELIZABETH BAILEY

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: JOSEPH [redacted] M. THOMAS Address: SAME AS # 2 ABOVE

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Arteriosclerotic CV disease — INTERVAL BETWEEN ONSET AND DEATH: 10yrs
DUE TO
(b):
DUE TO
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Senile dementia

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Sept 1, 1966, to Oct 7, 1967, that (I) (we) last saw the deceased alive on Oct 6 19[illegible], and that death occurred at _____ M., from causes and on the date stated above

22a. SIGNATURE: J. Roy Guyther M.D. — M.O. ATTENDING PHYS. ☒ MED DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 10-10-67

22c. PHYSICIAN'S NAME (Type): J. ROY GUYTHER M. D.

22d. ADDRESS: MECHANICSVILLE, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: OCT 9, 1967

23c. NAME OF CEMETERY OR CREMATORY: SACRED HEART CEMETERY

23d. LOCATION (City or Town) (County) (State): BUSHWOOD, ST. MARY'S, MD.

24. FUNERAL DIRECTOR ADDRESS: W. CLARKE MATTINGLEY LEONARDTOWN, MARYLAND

25a. REC'D BY REGISTRAR DATE: OCT 16 1967

25b. REGISTRAR'S SIGNATURE: [illegible] Judge

ROY GUYTHER

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

4459

CERTIFICATE OF DEATH

14167

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY: St. Mary's — MARYLAND	2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE: Maryland b. COUNTY: St. Mary's
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Leonardtown c LENGTH OF STAY IN 1b: 12 HRS	c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): California
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): St. Mary's Hospital	d STREET ADDRESS: Rt. 2 Box 360 e IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
Mary	Rebecca	Washington	October	24,	19 67

5 SEX	6 COLOR OR RACE	7 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	8 DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months / Days	IF UNDER 24 HRS Hours / Min
Female	Colored		June 29, 1885	82 yrs		

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b KIND OF BUSINESS OR INDUSTRY	11 BIRTHPLACE (County & State, or foreign country)	12 CITIZEN OF WHAT COUNTRY?
		Maryland	U.S.A.

13 FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Ben Chase	Rebecca Hopewell

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address
		Elizabeth Chase same as # 2 above

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a) Circulatory Collapse — INTERVAL BETWEEN ONSET AND DEATH: hrs

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: days

DUE TO

(c)

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d INJURY OCCURRED While at work ☐ Not While at work ☐	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)

21. I certify that (I) (~~this hospital~~) attended the deceased from Sept., 1967 to 10/24, 1967 that (I) (~~saw~~) last saw the deceased alive on 10/24, 1967 and that death occurred at 7:20 A.M. from causes and on the date stated above

22a. SIGNATURE	ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS ☐	22b. DATE SIGNED
James P. Jarboe M.D.		10/25/67

22c. PHYSICIAN'S NAME (Type)	22d. ADDRESS
James P. Jarboe M. D.	Great Mills, Maryland

23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE THEREOF	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION (City or Town) (County) (State)
Burial	Oct. 28, 1967	Holy Face Cemetery	Great Mills, St. Mary's, Md.

24 FUNERAL DIRECTOR ADDRESS	25a REC'D BY REGISTRAR DATE	25b REGISTRAR'S SIGNATURE
W. Clarke Mattingley Leonardtown, Maryland	OCT 27 1967	J. Charles Yeatman

VR A15 (4) 25M 1/67

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14460

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14468

1. PLACE OF DEATH
a. COUNTY: St. Mary's — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Leonardtown
c. LENGTH OF STAY IN 1b: DOA
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): St. Mary's Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: St. Mary's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Callaway
d. STREET ADDRESS: Rural
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Leonard — Middle: Howard — Last: White

4. DATE OF DEATH: Month: October — Day: 11, — Year: 19 67

5. SEX: Male

6. COLOR OR RACE: Colored

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: March 19, 1934

9. AGE (In years last birthday): 33 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Howard White

14. MOTHER'S MAIDEN NAME: Rose Beall

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes give war or dates of service):

16. SOCIAL SECURITY NO.: 217-28-2853

17. INFORMANT: Catherine E. White — Address: Callaway, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Laceration of brain — INTERVAL BETWEEN ONSET AND DEATH: immed
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Fractured skull — immed
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PEREORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Hit by auto

20c. TIME OF INJURY Month, Day, Year: Hour 1135 p.m. 10-11 1967

20d. INJURY OCCURRED While at work ☐ Not While at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street office bldg. etc.): Route 249

20f. (City or town): Callaway (County): St Mary (State): Md

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: W D Boyd M.D.

EXAMINER'S NAME (Type): William D. Boyd M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

Address (Street, city, town, or county):

22. DATE SIGNED: 10/12/67

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Oct. 14, 1967

23c. NAME OF CEMETERY OR CREMATORY: Holy Face Cemetery

23d. LOCATION (City or Town) (County) (State): Great Mills, St. Mary's, Md.

24. FUNERAL DIRECTOR: W. Clarke Mattingley — ADDRESS: Leonardtown, Maryland

25a. REC'D BY REGISTRAR DATE: OCT 17 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14461 — 14469

FOR STATE HEALTH DEPT.

1. PLACE OF DEATH
a. COUNTY: ST MARY'S — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): NEAR PINEY POINT
c. LENGTH OF STAY IN 1b: N/A
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): POTOMAC RIVER

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: VIRGINIA
b. COUNTY: NEWPORT NEWS
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): NEWPORT NEWS
d. STREET ADDRESS: 737 ADAMS DRIVE, APT 7A
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: DENNIS — Middle: ANTHONY — Last: WROBLESKI

4. DATE OF DEATH: Month: OCTOBER — Day: 10 — Year: 19 67

5. SEX: MALE

6. COLOR OR RACE: CAU

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 11 JULY 40

9. AGE (In years last birthday): 27 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): ARMY AVIATOR

10b. KIND OF BUSINESS OR INDUSTRY: U.S.ARMY

11. BIRTHPLACE (State or foreign country): CLEVELAND, OHIO

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: THADDEUS ANTHONY WROBLESKI

14. MOTHER'S MAIDEN NAME: HARRIETT DLUZYNSKI

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): Yes 25Aug62-Present

16. SOCIAL SECURITY NO.: 273388323

17. INFORMANT — Address: U.A.ARMY RECORDS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) SEVERE OPEN CRUSHING HEAD INJURY WITH BRAIN
860X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b) LACERATION AND CONTUSION ASSOCIATED WITH
DUE TO LACERATION AND RUPTURE OF HEART ASSOCIATED
DUE TO AIRCRAFT ACCIDENT
(c)

INTERVAL BETWEEN ONSET AND DEATH: INSTANT

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): MULTIPLE FRACTURES OF EXTREMITIES;CRUSHING CHEST INJURIES

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☒ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.): FORCESOF SUDDEN DECELLERATION WHEN AIRCRAFT CRASHED

20c. TIME OF INJURY Month, Day, Year: Hour 10:45 a.m. xx. Oct 10 19 67

20d. INJURY OCCURRED While at work ☒ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Airplane

20f. (City or town) (County) (State): Potomac River, St Mary's, Md

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: W D Boyd M.D.

EXAMINER'S NAME (Type): WILLIAM D.BOYD, MD

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

Address (Street, city, town, or county)

DATE SIGNED: OCT 13, 1967

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Oct 14 '67

22c. NAME OF CEMETERY OR CREMATORY: Calvary Cemetery

22d. LOCATION (City, town, or country) (State): Cleveland, Ohio

23. FUNERAL DIRECTOR: Howard County Funeral Home of Harry Witzke

ADDRESS: Ellicott City, Md

24a. REC'D BY REGISTRAR DATE: NOV 15 1967

24b. REGISTRAR'S SIGNATURE: Charles Judge

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any ... is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the ... director. Page 4 should be ... or your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
5M 1/62

ORIGINALLY REPORTED ON REGULAR DEATH FORM AND SHOULD HAVE BEEN M.E.

FILM G394 - 11/15/67 - mnb